SERFF Tracking Number:	*AULD-127685909*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49976*
Company Tracking Number:	*STATEMENT OF INSURABILITY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.004 Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Filing at a Glance

Company: American United Life Insurance Company

Product Name: Statement of Insurability	SERFF Tr Num: AULD-127685909	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Approved	State Tr Num: 49976
Sub-TOI: H11G.004 Other	Co Tr Num: STATEMENT OF INSURABILITY	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Donna Lambert
	Authors: Bridget McGill, Angie Neville, Danita Ragland-Hatton	Disposition Date: 10/12/2011
	Date Submitted: 10/07/2011	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date: 11/14/2011

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type:	Group Market Size: Small
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 10/12/2011	
State Status Changed: 10/12/2011	Deemer Date:
Created By: Angie Neville	Submitted By: Angie Neville
Corresponding Filing Tracking Number:	
Filing Description:	

October 7, 2011

Re: American United Life Insurance Company - NAIC #60895
Statement of Insurability, G-23223-EOI
Form to be used with Group Life and Disability Income Insurance and Individual Life Insurance forms

Dear Department of Insurance:

SERFF Tracking Number:	*AULD-127685909*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49976*
Company Tracking Number:	*STATEMENT OF INSURABILITY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.004 Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Attached for approval is the Statement of Insurability form. This form is new and does not replace any existing forms on file with your Department. This form may be used when applying for the following products on file with your department: (1) group term life insurance; (2) group disability insurance; and (2) individual life insurance. We are filing under life and disability separately. The Life SERFF tracking number for life is AULD-127685512. This form was filed in our domiciliary state, Indiana, on September 30, 2011, and is pending approval.

This form will be used at enrollment to medically underwrite individuals who apply for:
·An amount of group term life insurance coverage or group disability income insurance coverage above the Guaranteed Issue Amount;
·Group term life insurance coverage or group disability income insurance coverage as a Late Enrollee;
·A change in group term life insurance coverage or group disability income insurance coverage if the policy requires the completion of evidence of insurability; or
·Individual life insurance coverage

American United Life Insurance Company (AUL) wishes to market individual whole life insurance to employees whose employers have group insurance with AUL. So the employee does not have to answer underwriting questions twice, once with the whole life insurance application and then again, where appropriate, when enrolling for group coverage, this Statement of Insurability form will be used to medically underwrite for both the whole life insurance and if applicable, for the group insurance products as listed above.

Variable language has been marked with brackets which generally indicate optional benefits or provisions. If the language is changed, it will never be less favorable than your state's laws allow.

Please acknowledge approval of this form via SERFF.

You may call me at 317-285-1809 or contact me by e-mail at productcompliance.corporatecompliance@oneamerica.com if you have any questions. Thank you for your assistance with this filing.

Sincerely,

Bridget McGill
Senior Contract Analyst
Corporate Compliance and Market Conduct

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*AULD-127685909*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49976*
Company Tracking Number:	*STATEMENT OF INSURABILITY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.004 Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Bridget McGill, Sr. Contract Analyst
One American Square
Indianapolis, IN 46206
Bridget.McGill@oneamerica.com
317-285-1809 [Phone]

Filing Company Information

American United Life Insurance Company
One American Square
P.O. Box 7127
Indianapolis, IN 46206
(877) 285-7660 ext. [Phone]

CoCode: 60895
Group Code: 619
Group Name:
FEIN Number: 35-0145825

State of Domicile: Indiana
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American United Life Insurance Company	$50.00	10/07/2011	52582415

SERFF Tracking Number:	*AULD-127685909*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49976*
Company Tracking Number:	*STATEMENT OF INSURABILITY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.004 Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/12/2011	10/12/2011

SERFF Tracking Number:	*AULD-127685909*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49976*
Company Tracking Number:	*STATEMENT OF INSURABILITY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.004 Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/12/2011
Implementation Date: 11/14/2011
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AULD-127685909*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49976*
Company Tracking Number:	*STATEMENT OF INSURABILITY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.004 Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	No
Supporting Document	Application	Approved	No
Supporting Document	Statement of Variables	Approved	No
Form	Statement of Insurability	Approved	No

SERFF Tracking Number:	*AULD-127685909*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49976*
Company Tracking Number:	*STATEMENT OF INSURABILITY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.004 Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: G-23223-EOI

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/12/2011	G-23223-EOI	Application/ Enrollment Form	Statement of Insurability	Initial		50.200	G-23223-EOI.pdf

Statement of Insurability

Products and financial services provided by
American United Life Insurance Company®
a OneAmerica® company
One American Square, P.O. Box 368
Indianapolis, IN 46206-0368
1-800-553-5318

OneAmerica®

Section A: Proposed Insured *(complete Statement of Insurability)*

Proposed Insured Name: ____________________

Driver's License Number ____________ State where Issued ____________

Height ______ ft. ______ in. Weight ______ lbs. ☐ Gained ☐ Lost ______ lbs. In Past Year

Spouse and/or Child(ren) must complete Statement of Insurability if required for Group Coverage.
Whole Life Insurance Coverage not available for Spouse/Children.

Spouse/Partner Name *(Last, First, Middle)* — Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Driver's License # ______ State where Issued ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)* — Relationship to You ______ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)* — Relationship to You ______ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)* — Relationship to You ______ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Child Name *(Last, First)* — Relationship to You ______ Full-Time Student ☐ Yes ☐ No
Gender ☐ M ☐ F Birth Date ______ Birth Place ______
Height ______ Weight ______ Authorized to Reside in U.S. ☐ Yes ☐ No

Underwriting Information

Section B: Health Questions

1. Within the past 7 years, has any applicant for insurance been diagnosed or treated by a physician or medical professional, tested positive for the presence of, or taken prescribed medicine for the following: ***(Circle conditions that apply in multi-condition questions, and provide full details to any "yes" response in Section 4.)***

	Proposed Insured	Spouse	Children
a. Cancer, malignancy, or tumor of any kind?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Diabetes, thyroid, or other glandular disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Chest pain, angina, or heart attack; heart disease/disorder or murmur, peripheral vascular disease, elevated cholesterol or triglycerides?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. High blood pressure or hypertension?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Anemia, bleeding disorder, clotting disorder or other blood disease or disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Neurological or brain disorder, seizures, epilepsy, paralysis, multiple sclerosis, ALS or Lou Gehrig's disease, Parkinson's disease, Alzheimer's, other forms of dementia/cognitive disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Stomach or intestinal disorder, Crohn's, irritable bowel disorder, diverticulitis, GERD/reflux?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Stroke or transient ischemic attack (TIA)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Kidney, urinary bladder, gallbladder, pancreas, liver disorder or hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. Psychological, psychiatric, or emotional disorder, depression, anxiety, stress?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. Lung or respiratory disorder/disease, shortness of breath, asthma?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l. Neuromuscular, musculoskeletal disorders, lupus, arthritis, neck-, back-, knee- or foot disorders, other joint disorder, fibromyalgia, or chronic fatigue syndrome?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m. Skin or lymph node disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n. Eye, ear, nose, mouth, or throat disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC), or any immune deficiency related disorders?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p. Prostate or testicular disorder, female reproductive organ disorder, or sexually transmitted disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section B: Health Questions *(continued)*

2. Within the past 5 years, has any applicant for insurance: ***(Circle information that applies in multi-part questions, and provide full details to any "yes" response in Section 4.)***

	Proposed Insured	Spouse	Children
a. Had a checkup or consultation with a physician or medical practitioner?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Been an inpatient or outpatient in a hospital, clinic, or medical facility or any similar entity?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. Taken in the past, or is currently taking, any prescription medicine?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. Had an EKG, x-ray, blood study, urinalysis, treadmill, heart cath, MRI, CT scan, biopsy, or any other diagnostic testing?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. Been advised to have any diagnostic test, hospitalization, or surgery which has not been completed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. Made a claim or received benefits, compensation, or pension for any injury, sickness, disability, or impaired condition, and/or been unable to work, attend school, or perform the normal activities of like age and gender or been confined at home?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. Received or been instructed to seek treatment for use or abuse of: ☐ Alcohol ☐ Drugs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates, inhalants, or any other habit-forming drug or substance, whether prescribed or non-prescribed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. Had any surgical procedure for weight loss? If so what was date of surgery? _____ What was your pre-surgery weight? _____ lbs.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j. Been rejected, declined, rated, postponed, or modified for life or disability insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k. Had any illness, disease, injury, operation, or treatment other than stated above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

3. Currently, is any Applicant: ***(Provide details to any "yes" response in Section 4.)***

a. Pregnant? Expected delivery date: _____ *(List current or past complications or high risk issues, including but not limited to pregnancy related high blood pressure, diabetes multiple gestations, i.e., twins, etc in Section 4.)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Has any applicant ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products? If Yes, provide detail below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name _____

1. ☐ Present ☐ Former
2. Type of nicotine or tobacco used: _____
3. When did the applicant quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year

If more than one applicant has used nicotine, provide full details in Section 4.

4. Describe details of each "yes" response from Questions 1-3. If needed, use separate sheet of paper.

Name	*Question No.*	*Details of injury, illness, or disorder*	*Date*	*Name of Physician, Hospital, or Other Provider*

Authorization and Acknowledgement

I/we authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about me (and my spouse and/or my dependents, if they are to be insured): facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. **This authorization does not authorize the release of genetic screening or testing results.** All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date shown below. In Arizona, this authorization is limited to 180-days for disclosure of HIV-related information. I/we understand that any person requesting to be insured may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made, I/we can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my/our knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) I/we certify that all notices contained herein were read and understood prior to my/our completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgment.

Signatures

Signature of Proposed Insured / Employee *Mo. / Day / Year*

Printed Name of Proposed Insured / Employee

Signature of Spouse / Partner *Mo. / Day / Year*

Printed Name of Spouse / Partner

Signature of Dependent Child Age 18+ *Mo. / Day / Year*

Printed Name of Dependent Child Age 18+

SERFF Tracking Number:	*AULD-127685909*	*State:*	*Arkansas*
Filing Company:	*American United Life Insurance Company*	*State Tracking Number:*	*49976*
Company Tracking Number:	*STATEMENT OF INSURABILITY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.004 Other*
Product Name:	*Statement of Insurability*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	10/12/2011

Comments:

Attachments:

Standard Cert of Compliance _Blank_.pdf

READCERT.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	10/12/2011
Bypass Reason:	N/A		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variables	Approved	10/12/2011

Comments:

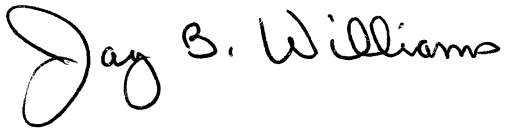
Attachment:

Statement of Variables - G-23223-EOI.pdf

CERTIFICATE OF COMPLIANCE

State of Arkansas

I, Jay B. Williams, Vice President Chief Compliance Officer, of the AMERICAN UNITED LIFE INSURANCE COMPANY®, hereby certify that the enclosed Forms comply with all Insurance Statutes, Regulations, and Departmental requirements of the State of Arkansas.



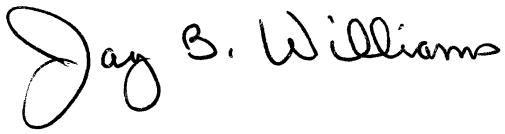
Jay B. Williams
Vice President Chief Compliance Officer

Date: October 6, 2011

CERTIFICATE OF READABILITY

I, Jay B. Williams, Vice President and Director of Compliance of American United Life Insurance Company, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements.

FORMS	READABILITY SCORE
G-23223-EOI	50.2



October 6, 2011

Jay B. Williams
Vice President and Director of Compliance

STATEMENT OF VARIABLES
G-23223-EOI

FORM NUMBER	SECTION TITLE	PROVISION/ DESCRIPTION	BRACKETED VARIABLES EXPLANATION
G-23223-EOI	Statement of Insurability	Company address/phone number	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
"	"	OneAmerica (logo)	Bracketed for ease in updating the logo in case it is changed.
"	Section A	Spouse and children	Bracketed so the spouse and children questions may be deleted if evidence of insurability information for spouse and children are not applicable. Bracketed for ease in updating as need arises whenever there is a change in product(s) offered to the spouse and children– the change could be in a product name or it could be a new product that has been filed and approved by the state
"	Section B	Spouse and Children columns	Bracketed so the spouse and children area may be deleted if evidence of insurability for spouse and children are not applicable.
"	Authorization and Acknowledgement	"I/we", "my/our" and "(and my spouse and/or my dependents, if they are to be insured)"	Bracketed so the references to spouse and children may be deleted if evidence of insurability for spouse and children are not applicable.
"	Signatures	Signatures for Spouse and children	Bracketed so the spouse and children signature items may be deleted if evidence of insurability for spouse and children are not applicable.